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We celebrate our 75th anniversary by renewing our commitment to bring hope, health and healing to our community with continuing innovation and the utmost in compassionate care.
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Kalo

Taro was cultivated as the staple food of old Hawaii.

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Editorial

Norman Goldstein MD
Editor, Hawaii Medical Journal

Sick Buildings - Sick Patients

For several decades, I have read about sick building syndrome and have heard that Hawaii is having problems in its high-rise buildings. Hawaii has more than its share of environmental allergens, giving it the reputation as an allergy capital of the country. The combination of high humidity and year round warm weather makes paradise the ideal “petri dish” for fungi, molds, pollen, mites, and other allergens.

This problem became acutely personal when my wife and I became sensitive to molds in our downtown condo with central air-conditioning, prompting us to purchase a home. After living there for 18 years, new air-conditioning improperly installed increased humidity and a variety of molds suddenly proliferated, forcing us to seek a well-ventilated and mold-free environment. This is an all too frequent occurrence for families in Hawaii.

Despite regular servicing of a building’s air conditioning system, the growth of mold can outpace the most meticulous methods of control. Recently, CNN News interviewed Jeffrey May, the author of My House is Killing Me! Writer May is an indoor environmental specialist with vast experience in what has become a major worldwide health problem. While allergists and pulmonologists are aware of these problems, other medical specialists generally are not. This book is suggested reading for practicing physicians, especially in mold-provoking areas, and should be recommended to patients suffering attendant respiratory distress.

Air pollution indoors can be ten times more prevalent than outdoors in Los Angeles on a bad day, no matter where you live, according to the American Formulating and Manufacturing Association. The Environmental Protection Agency estimates that indoor air pollution kills more than 11,000 people every year.

In the longest study of indoor and outdoor fungal concentrations, Shelton et al studied 1,717 buildings and found there was no one species of mold associated with illness in the occupants. In the three-year study, the most common mold species, indoors and outdoors, were Penicillium, Aspergillus, Cladosporium, and non-sporulating molds. Stachybotrys chartarum, the “toxic black mold,” which contains macrocyclic trichothecones, was found in 6% of the buildings studied and in 1% of the outdoor air samples.

Unfortunately, even after molds are identified, control after an outbreak may be difficult or impossible to eradicate. Sensitive people may have to relocate to avoid these environments.

Hospitals are also potential breeding grounds for mold problems. An article in Hospital Materiel Management Quarterly by Brownson reports that some people become very seriously ill just by breathing indoor air. This is a problem in all industrial buildings, and Brownson suggests that hospital staff are at particular risk, and that hospital managers should endeavor to make the air safer for staffs and patients. A MedLine review of the “Sick Building Syndrome” reveals that this is a worldwide problem with several texts on the subject currently available. A special hospital in Japan is researching this burgeoning environmental problem.

Continued on next page
Letter to the Editor

Medical Records Privacy

Why are we going backwards on the subject of Privacy of Medical Records?

The proposed changes to the HIPAA privacy rule announced two weeks ago by the Department of Health and Human Services (HHS) loosen restrictions on providing care before obtaining consent and discussing patient care out loud with other clinicians.

Just as the MD credential obligates Medical Doctors to adhere to the tenets of the Hippocratic Oath, the credential of RHIA obligates Registered Health Information Administrators to tenaciously protect the confidentiality of private medical information on behalf of patients at all times. Because there was never Federal regulation to protect this private health information, this has been a challenging task at best. Also, patients have not always been aware of how their medical information was being used and what they could do to direct that use.

Fortunately, the HHS along with the Office of Civil Rights have been strategically positioned by the HIPAA Privacy standards to improve this legacy while expediting patient care and payment to providers for that care. That was, until March 22, 2002.

Don’t forget that as a country, we have invested somewhere between $10 and $15 billion dollars on healthcare information technology since 1996. Healthcare professionals have made the collection of patient data, the conversion of that data into useful information and access to that information infinitely simpler than anytime in the past. Our government had the foresight to know that with this massive investment, we needed a system to protect this easily accessible information in the spirit of ensuring the “zone of privacy” it seeks to provide its citizens through various laws regarding private information.

We should proceed cautiously in modifying the HIPAA privacy regulations. Recall the original intent of these privacy regulations with these examples from the Federal Register of December 28, 2000:

- 35% of Fortune 500 companies look at an applicant’s medical records prior to making hiring decisions
- A Health System posted records of thousands of patients on the Internet
- A Health Department employee took a disk with the names of 4,000 people who had tested positive for HIV
- A woman purchased a computer that still contained prescription records of pharmacy customers
- A banker who also sat on a county health board gained access to patients cancer records and called in their mortgages

Do we really need more evidence than this that we should not allow the other protections (e.g., civil monetary penalties, imprisonment for using or selling protected health information for personal advantage, personal gain or malicious harm) provided in the HIPAA privacy regulations to be carved away until we find ourselves back at square one?

Administrative simplification was the original intent of the HIPAA regulations. Those of us responsible for running and operating healthcare organizations have questioned this as we have learned more about the arduousness of implementing various HIPAA provisions. It isn’t going to be easy. As leaders, it’s time for us to step up and figure out how best to implement these regulations, share the successful methods for doing so with our colleagues in the healthcare community and maintain the protections that we as citizens have been provided.

Beth A. Kost, RHIA
Corporate Compliance Officer
Vice President, Professional Services
Precyse Solutions

Editor’s Note:
Beth Kost has worked in Health Information Management for more than 16 years. She has served as a Senior Consultant for Ernst & Young in its Health Care Consulting Practice in Washington D.C. Kost joined Precyse in 1998. In 1999, she became Chief Operating Officer and in 2002 she joined the corporate team as Vice President of Professional Services. HIPAA and Corporate Compliance Officer. Kost is a graduate of Bowling Green State University.

"Editorial,” continued from p. 116

Perhaps this is the time for our Medical School to plan an environmental medicine department in the proposed Kakaako facility.

References

Until there’s a cure, there’s the American Diabetes Association.
Outcome of 5,000 Flexible Sigmoidoscopies done by Nurse Endoscopists for Colorectal Screening in Asymptomatic Patients

Ankur Jain, John Falzarano MD, Amod Jain MD, Robert Decker MD, Gail Okubo RN, and Daryl Fujiwara MD

Abstract

Objectives: There have been several studies to date establishing the efficacy of nurse endoscopists in colorectal screening. However, no such study has ever been conducted in Hawaii. Utilizing the large sample size of our study, we hope to further support endoscopy by nurses as both a safe and cost-effective means of screening for colon cancer.

Methods: This is a retrospective study of the results of more than 5,000 flexible sigmoidoscopies done by nurse endoscopists in the colorectal screening clinic at Kaiser Hospital in Honolulu, Hawaii, between November 1995 and February 2001. These results were separated into normal, non-neoplastic polyps, adenomas, and cancer.

Results: The rate of detection of polyps was 13.3% (non-neoplastic and adenomas). Colon cancer was detected in 15 patients (3% detection rate), of which 8 were carcinoma in situ, 3 were Dukes A, 2 were Dukes B1/B2, and 2 were Dukes C2. Clinically significant lesions (ie. carcinoma, large adenomas, or atypical adenomas) were found in 1.8% of all patients. There were 8 carcinoids, 1 lipoma, 2 condylomas, and 3 leiomyomas detected. For patients who underwent colonoscopy, no other significant lesions were found in the areas examined by nurse endoscopists. There were no complications, i.e. perforation, bleeding, infection, and death, in any of the patients.

Conclusion: The results of our study emphasize the importance of being screened for colorectal cancer. Nurse endoscopists can safely and effectively perform flexible sigmoidoscopies. By training more nurse endoscopists, we can increase the rate of colorectal screening in a cost-effective manner.

Purpose

Over 150,000 cases of colorectal cancer are diagnosed in the United States yearly. Over 90% of these patients are over the age of 50. As the United States population ages, over 50 million Americans will be eligible for colorectal cancer screening. Although screening flexible sigmoidoscopy is associated with a significant decrease in colorectal cancer mortality, only 30% of eligible patients have undergone sigmoidoscopy. The projected increase in a population eligible for screening is expected to increase demand for this procedure and may overwhelm currently available endoscopic resources. Screening flexible sigmoidoscopy by nurse practitioners is the most cost-effective method available currently to reduce colorectal CA mortality. The purpose of this study is to evaluate the outcome of 5,000+ flexible sigmoidoscopies done at the Kaiser GI clinic between November 1995 and February 2001.

Subjects and methods

Patients were referred to the colorectal screening clinic if they met the following criteria:

- between 50 and 75 years of age (or above the age of 75 without any major medical conditions)
- free of GI symptoms
- no first degree relatives diagnosed with colorectal cancer below the age of 60
- not at high risk for developing colorectal CA:
  ▲ no family history of familial adenomatous polyposis, juvenile polyposis, or other hereditary polyposis conditions
  ▲ no family history of hereditary non-polyposis colorectal cancer
  ▲ no personal history of adenomatous polyps
  ▲ no personal history of colorectal cancer
  ▲ no inflammatory bowel disease
  ▲ tested negative for fecal occult blood

Registered GI nurses who worked in the GI department for at least 2 years assisting gastroenterologists with colonoscopies were eligible for training in screening flexible sigmoidoscopy. They performed a minimum of 50 supervised flexible sigmoidoscopies prior to functioning independently. They were trained to perform biopsies of polyps less than 5mm in size, and consulted gastroenterologists for patients with polyps of larger size and/or multiple polyps.
Initially, patients were recommended to have colonoscopy done for all adenomas. Later however, colonoscopy was limited to those adenomas greater than 9 mm in size, smaller polyps with abnormal histology, e.g., atypia, and multiple small polyps found on sigmoidoscopy. The decision whether or not to proceed with colonoscopy for adenomas between 6 and 9 mm size was left to the discretion of the gastroenterologists. This decision was based on the publication “Clinical practice guidelines for colorectal cancer screening.” A similar screening strategy has been found to be the most efficient in terms of colonoscopies generated and cases of colorectal cancer detected.

Results
The rate of detection of polyps was 13.3% (666/5017), out of which 290 (5.8%) were non-neoplastic and 376 (7.5%) were adenomas (Table 1). This is similar to published rates of detection by physicians performing flexible sigmoidoscopy. Table 2 breaks down adenomas by size.

Colorectal cancer was detected in 15 patients (.3% detection rate), out of which 8 were carcinoma in situ, 3 were Dukes A, 2 were Dukes B1/B2, and 3 were Dukes C2. See Tables 1 and 3. Upon reviewing the literature, there has been no consistent rate of colon cancer detection by physicians.

Lesions were found to be clinically significant, i.e., carcinoma, adenomas with atypia, or large adenomas, in 1.8% (91/5017) of all patients.

There were 8 carcinoids, 1 lipoma, 2 condylomas, and 3 leiomyomas detected (Table 1).

For patients who underwent colonoscopy, no other significant lesions were found in the areas examined by nurse endoscopists.

There were no complications, i.e., perforation, bleeding, infection, and death, in any of the patients encountered. Upon reviewing the literature, flexible sigmoidoscopy by physicians carries a .004% risk of perforation. Colorectal cancer is associated with a much higher rate of perforation, .19%, and a .019% risk of death.

Discussion
Nurse endoscopists in our clinic safely and effectively performed over 5,000 screening flexible sigmoidoscopies. They detected clinically significant lesions (carcinoma, adenomas with atypia, or large adenomas) in approximately 1 out of every 56 asymptomatic patients. In addition, there were no complications from any of these procedures.

Several studies have explored the role of nurses in screening sigmoidoscopy. Schoenfeld et al. randomized patients to undergo screening flexible sigmoidoscopy by a nurse endoscopist or by a gastroenterologist. No differences in detection of adenomatous polyps or frequency of complications were found.

In the largest of these studies, Wallace et al. reported the results of sigmoidoscopic screening by nurse practitioner (NP) and physician assistant (PA) endoscopists and gastroenterologists at a large institution. Polyps were detected in 23% of the examinations by physicians and in 27% of the examinations by NPs and PAs. After screening over 9,500 patients, the authors noted a 10% incidence of adenomatous polyps and a .32% incidence of colorectal cancer. These findings are similar to those of other large organizations that offer colon cancer screening using flexible sigmoidoscopy.

Because our study of colorectal screening by nurse endoscopists was retrospective in nature, we could not directly compare our results with those of physician endoscopists. However, after undergoing sigmoidoscopic screening by nurses, no significant lesions were found in the rectosigmoid area on follow-up colonoscopy.

Colonoscopy is the most sensitive method of screening for colorectal lesions. However, it is not feasible at this time to perform colonoscopy as a tool for mass screening because of the limited availability of gastroenterologists, the high cost of colonoscopy, and the complications associated with this procedure.

Several studies have shown the utility of fecal occult blood screening in reducing the incidence of colorectal cancer. Flexible sigmoidoscopy of guia negative patients by nurse endoscopists has been shown to be the most cost-effective method of screening the general population for colorectal cancer. In our opinion, this should become the primary large-scale screening tool for colorectal carcinoma in patients of average risk.

Conclusion
Nurse endoscopists can safely and effectively perform screening flexible sigmoidoscopy. Given the large number of significant lesions detected by nurse endoscopists in our study, their role in performing flexible sigmoidoscopy should be expanded in order to keep up with the increasing demand for colorectal cancer screening in the U.S.

Acknowledgement
We are grateful to the staff of the Kaiser GI department for helping us with this study.

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Robert Decker MD, gastroenterologist, Kaiser Hospital
Daryl Fujiwara MD, gastroenterologist, Kaiser Hospital
Gail Okubo RN, Supervisor of GI Department, Kaiser Hospital
Ankur Jain, visiting 4th year medical student, Northwestern University

References
### Table 1.— Total flexible sigmoidoscopies performed

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<td>1018</td>
<td>1034</td>
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<td>Normal or no significant pathology</td>
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<td>Non-neoplastic polyps</td>
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### Table 2.— Breakdown of adenoma

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<td>73</td>
<td>71</td>
<td>69</td>
<td>75</td>
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<td>Adenoma &lt;6mm</td>
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<td>Adenoma 6-9mm</td>
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<td>Adenoma &gt;9mm or adenoma with atypia</td>
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<td>76</td>
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### Table 3.— Breakdown of adenocarcinoma

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Pain Assessment in Hawaii Nursing Homes
Marya Levintova-Romero PhD and Carolyn Cook Gotay PhD

Abstract
Nursing home personnel from adult long-term care facilities on Oahu were surveyed on their pain assessment practices with demented and non-verbal residents. Many reported having difficulties evaluating pain in these residents. Observation and standardized pain assessment scales were most frequently used pain assessment methods. Recommendations are made about how to improve pain assessment with demented and non-verbal patients.

Introduction
The population of individuals over the age of 65 in Hawaii is growing at a rapid rate. It is estimated that this group of elderly will double by the year 2025.1 However, extended life expectancy and increasing age are associated with likelihood of living with chronic and/or disabling conditions, many of which are associated with experiences of pain. The consequences of untreated pain can be dire, including depression, fatigue, decreased socialization, sleep and appetite changes, and increased physical disability.2,3

Studies on the prevalence of pain among community and nursing home residents indicate ranges from 25% to 80%.4,5,6-21 A recent Minimum Data Set (MDS) report by the American Medical Association determined that 2.2 million of nursing home residents across the United States suffer from persistent pain.9 In Hawaii, in 1999 there were 5,268 nursing home residents, with nearly 38% reporting experiencing severe pain.9 These ratings were collected through an analysis national repository of MDS data.

Assessment of pain among nursing home patients is crucial and is the initial step in treatment planning. Furthermore, research indicates that inappropriate pain assessment measures used for pain detection result in under-diagnosis and under-treatment of pain.10-12 In addition, reporting habits of the elderly, acceptance of these pain reports by the medical professionals and their reluctance to administer analgesics to frail elderly13 are additional factors in poor pain treatment. Patient communication, memory and/or emotional disabilities can also hinder pain assessments.

A number of studies evaluated appropriateness of various pain assessment tools to be used with non-verbal, confused, demented, and cognitively impaired elderly.11,14,15 These pain assessment approaches can be divided into two categories: behavioral observation and patient self-report. Behavioral observation methods include, but are not limited to, observation of changes in behavior and functioning including sleep, appetite, physical activity, mobility, and facial/body language. A number of behavioral observation schedules have been developed.14,15,16-19 Several patient self-report scales are also available, as seen in Figure 1.

However, nurses and direct care personnel may not be aware of such assessment tools, and may rarely, poorly or inconsistently use them.25 According to Coyne and colleagues, nursing and medical personnel are usually poorly trained in pain assessment, with most receiving 1-4 hours of pain management content during their curricula.26

In this study we inquired regarding pain assessment practices among nursing home/direct patient care personnel on the island of Oahu, Hawaii. The respondents were all asked about their use of published and well-researched pain assessment measures. The measures (Figure 1) selected included both observational and patient self-report assessment tools. We did not provide specific descriptions and/or information regarding the assessment measures.

Methods
A non-experimental design and a descriptive approach were used to examine pain assessment techniques among nursing homes and extended geriatric care facilities on the island of Oahu, Hawaii. A fourteen-item survey was mailed to 23 nursing homes/extended care facilities listed in the GTE Pages Directory for Oahu.

Participants
9 out of 23 nursing homes/extended care facilities responded to the survey. 78% of the facilities were located in Honolulu (n=7). Two facilities were located outside of Honolulu, one of the Windward side of Oahu, another on the North Shore. Numbers of beds in the facilities that participated ranged from 5 to 182 (Mean number of beds = 70). A total of 20 individual surveys were returned com-
pleted. Overall response rate was 39%, with an average of one participant from each of the facilities (range of participants per institution 1-5). 90% of the surveys were completed by females (n=18). 30% of the respondents had an Associate’s Degree (n=6), and 25% were Registered Nurses (n=5). Equal number of respondents had a Master’s in Nursing Degree (n=4) or a combination of degrees (n=4). One participant was a Licensed Practice Nurse.

**Instruments**

A 14-item survey was constructed that included both closed- and open-ended questions. This survey was developed specifically for this study. The survey included items on demographics, pain assessment tools, frequency of pain assessment, whether report of pain is recorded, and whether participants experienced difficulty in assessing presence of pain and intensity among the non-verbal and demented residents.

**Statistics**

All of the variables were analyzed using descriptive statistics.

**Results**

100% of the participants reported that they treat pain and painful conditions at their facility. We did not inquire about the age range of the patient population; however, 100% of respondents reported their facilities treat individuals over the age of 65. 60% of participants reported that they conduct pain assessments with every patient they work with during their shift, and all of them reported that they record their evaluations following each inquiry. However, only 40% reported that they conduct pain assessments on a schedule (i.e., at the same time of day), regardless of the presence or absence of pain complaints from the patient. 70% of participants reported consistency with pain assessment measure(s) (i.e., using same assessment procedure(s) with the same patient). The most frequently utilized approach used by 35% of respondents, was a combination of behavioral observation, faces (i.e., a row of human faces with the range of facial expressions) and verbal analog scales, followed by the combination of behavioral observation, faces, visual and verbal analog scales (30%). 15% of participants reported using both observation and verbal analog scales, 10% reported using the McGill (a standardized pain questionnaire), and 5% reported using a combination of behavioral observation, visual and verbal analog scales. Other pain assessment methods reported included observation of changes in mood, physical functioning (e.g., appetite, sleep, movement), motor agitation, and facial grimacing. Frequency of pain assessment during a single 8-hour shift varied greatly: 35% of participants stated that they evaluate pain on an “as needed” basis; 25% ask once during their shift; 25% ask twice; 5% ask 3 times; 5% ask 4 times; and 5% ask 10 times. 75% of participants responded that they find it difficult to assess presence of pain among patients with dementia. 65% indicated having difficulties evaluating presence of pain among patients who are non-verbal.

**Discussion**

This study is the first one to document pain assessment practices in nursing homes on the island of Oahu, Hawaii. Due to a small number of participants and an incomplete response rate, it is difficult to make definitive conclusions about the quantity and quality of pain assessment practices. Furthermore, due to a limited number of facilities with multiple participants, we are unable to report on any differences in pain assessment methods by different personnel in the same facility. Further research utilizing larger, more complete samples is recommended. Such studies will provide information regarding pain assessment and treatment practices in Hawaii to contribute to future program planning.

Although our findings are not conclusive, we did find that most care personnel reported having difficulties evaluating pain in demented and non-verbal elderly. This is a serious concern, since many nursing home residents suffer from cognitive and other conditions that affect their ability to communicate about their concerns, including pain.

A number of ways to improve pain assessment practices among nursing home personnel can be suggested. Awareness about potential cultural differences in expression of pain and treatment seeking behavior in a culturally diverse population of Hawaii is one of the essential and necessary tools for successful clinical practice.

Learning about patient pain beliefs and myths about pain may assist health professionals to discuss some of the barriers experienced by patients and health practitioners about pain control. Professional training and continuing education should provide information on specific pain assessment tools and measures, teach about misconceptions on pain and aging, and provide hands-on experiences assessing difficult patients. Many professionals in this study are already using standardized pain assessment tools in their work, indicating a good foundation for further strengthening pain assessment skills. Improving multidisciplinary communication with primary care physicians in order to provide comprehensive care to nursing home residents is also very important.

Measures of patient self-report vary significantly by degree of complexity, ranging from extensive questionnaires and/or interview assessments, to brief visual, verbal and number rating scales. Many nursing home residents experience communication, comprehension, and sensory problems, making it difficult for them to respond to such assessment tools. Ferrell and colleagues reported that one out of five institutionalized patients they interviewed was unable to respond to “Yes” or “No” questions, therefore being unable to report presence and/or significance of their pain experience. Additionally, those individuals who were able to respond regarding presence of pain were unable to quantify their pain experience. Therefore self-report measures need to be designed using simple cognitive parameters that would enable nursing home residents to report and to quantify their pain.

Finally, care personnel need to be aware that not every pain assessment tool will be appropriate for every patient. Verbal, visual and/or faces scales may not be simple enough for demented and/or non-verbal elderly. These assessment tools require abstract thought, ability to recall previous experiences/events, comprehension, verbal ability, and ability to recognize emotions in self/other all of which are impaired in individuals with dementia and in some people who are unable to respond verbally to questions and instructions. Patient-administered and/or physician-, nurse-administered questionnaires generally are not appropriate to use with demented patients. However, some non-verbal patients who are cognitively intact may prefer to complete such measures, because it provides
them with an opportunity to report their concerns about their pain experience.

Flexibility and incorporation of pain measurements into patients’ daily routine are some of the ways to improve assessments and patient care. Because there is variability in patient pain behaviors, initial pain assessment should focus on regular observation of the patient in a number of daily activities. A measure frequently suggested in pain assessment literature is a brief observation schedule, developed by Simons and Malabar.11 This scale includes patient demographic information, a pain assessment chart to record time, response and site of pain, and a list of 25 observable pain behaviors. Observable behaviors include verbal responses to pain, facial expressions, body language, physiological changes, behavioral changes, feedback from others, and state of consciousness. This instrument represents a promising approach to use in nursing homes.

Pain assessment with demented and non-verbal patients is a critical issue, particularly since the number of individuals over 65 is growing rapidly in the State of Hawaii. Further research, training, and use of multidisciplinary treatment approaches will provide significant improvements in quality of life, physical and emotional functioning among nursing home patients.

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Center on Aging
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Never before in human history have so many individuals lived so long. This phenomenon has implications for individuals who experience a greater range of biological, psychological and social changes over a lengthening life span. It also has implications for families, communities, and societies that are influenced by, and must adjust to, a growing number and proportion of older adults.

The Center on Aging (COA) at the University of Hawaii is dedicated to enhancing the quality of life for Hawaii’s adults and elders. We accomplish this through: 1) undergraduate and graduate education; 2) continuing education for professionals and paraprofessionals; 3) research and evaluation; 4) organizational assistance with program and policy development; and 5) individual, community, and workplace education and outreach.

The COA was established in 1988 by the U. H. Board of Regents, which recognized the need for an interdisciplinary, campus-wide program for training students and facilitating education, research, and service in gerontology. Among its first achievements were the establishment of undergraduate and graduate certificates in aging and the production of a nationally distributed and acclaimed 13-hour telecourse on aging, called Growing Old in a New Age (1993). This video series is available at the Sinclair Library, University of Hawaii at Manoa.

In 1993, the COA was transferred to the School of Public Health and, with the demise of that school, integrated into the John A. Burns School of Medicine (JABSOM) in 2000. Since its inception, the COA has realized a number of accomplishments in each of its five activity areas.

Undergraduate and Graduate Education
- 44 students have been awarded an Advanced Certificate in Gerontology.
- 16 students have been awarded an Undergraduate Certificate in Aging.
- The Masters in Public Health (MPH) in gerontology was approved in 2001. Two students are graduating in 2002.
- Student research projects are funded through annual Lenzer-Goodfriend awards.
- The local chapter of Sigma Phi Omega, the National Gerontology Honor Society, is sponsored by the Center.

Continuing Education for Professionals and Paraprofessionals
- Staff serves as co-trainers of Educating Physicians in End-of-Life Care (EPEC).
- Staff provides training in end-of-life care for nursing home personnel, community-based service providers, and paraprofessional workers on Oahu and the Big Island.
- COA sponsors gerontology study tours to other countries and organizes study tours for professionals visiting Hawaii.
- Staff works with Papa Ola Lokahi to mentor Native Hawaiians who want to pursue research careers.

Research and Evaluation
- Our focus is on Asian and Pacific Islander aging, end-of-life care, family caregiving, successful aging, and Hawaiian health.
- Skills includes community-based participatory research, qualitative methods, developing and testing educational materials, and program evaluation.
- Since 1995, COA staff collaborated on and published 2 books, Teaching Students Geriatric Research with Peggy Parkinson, and Cultural Issues in End-of-Life Decision Making with Jim Pietsch (UH School of Law) Patricia Blanchette (JABSOM), 8 book chapters, 50 journal articles, 16 technical reports, and the 2nd, 3rd, and 4th editions of the study and faculty guides for Growing Old in a New Age.
- Staff has secured more than $2,000,000 in extramural funds.

Organizational Assistance with Program and Policy Development
- Staff assists governmental and non-governmental agencies with needs assessments, grant writing, policy development, program evaluation, and health communications.
- COA initiates contracts to implement programs of Hawaii’s Executive Office on Aging related to population aging, client satisfaction, data management, elder abuse prevention, end-of-life care, family caregiving, and self-determination.
- We assist other UH units and several non-UH agencies in securing their own grant funds, including the Executive Office on Aging, the Hawaiian Islands Hospice Organization, Papa Ola Lokahi, and the Hawaii Intergenerational Network.

Individual, Community, and Workplace Education and Outreach
- Publication of a semi-annual newsletter for faculty, students, alumni, and interested community members.
- Public training programs in advance directives, the aging process, care of the dying, care of the bereaved, coping with caregiver stress, cultural issues in caregiving and help-seeking, end-of-life decision making, and funeral planning.

Two of COA’s current projects include the End-of-Life Care for Hawaii’s Ohana (ECHO) and the Paraprofessionals in Aging Project (PAP). The purpose of the ECHO project is to explore the impact of group-targeted messages and individually tailored support on end-of-life planning by multi-ethnic caregivers of elders receiving long-term care services. To fit the needs of caregivers, ECHO uses the seven stages of caregiving outlined by Montgomery and Kosloski (2000) to design tailored, culturally sensitive end-of-life care messages for targeted groups of caregivers. This three-year project (funded by the Administration on Aging’s National Family Caregiver Support Program) includes the following community partners: Hawaii Meals on Wheels, Honolulu Gerontology Program, Koolau Kalili Valley Comprehensive Family Services, Maluhia Foundation, and Project Dana. The PAP is a 30-hour educational workshop.

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Cancer primary prevention clinical trials are different from disease-specific treatment trials. Prevention trials typically 1) include participants who are otherwise healthy, devoid of symptoms and thus require that toxicities or side effects from any intervention be minimal, 2) require large numbers of subjects to detect a difference between the intervention and control groups, and 3) require long study and follow-up periods to detect differences in outcomes related to all-cause survival, cancer-specific survival and quality of life. SELECT, the Selenium and Vitamin E Cancer Prevention Trial presented here, offers the opportunity to men in Hawaii to participate in a clinical trial and contribute to our scientific understanding and control of prostate cancer.

Carcinoma of the prostate is the most common tumor in the United States with 189,000 new cases and 30,200 deaths expected in 2002. In Hawaii, estimates for prostate cancer in 2002 are 700 new cases and 100 prostate cancer-related deaths.1 Histologic evidence of the disease may occur in as many as 34% of men in their fifth decade, and up to 70% of men 80 years of age and older. While one in five U.S. men will be diagnosed with prostate cancer during his lifetime, only 3% of men are expected to die of the disease. The menu of treatment options for localized prostate cancer includes radical prostatectomy, external-beam radiation therapy, brachytherapy, hormonal treatments or surveillance. Issues that confound the choice of treatment include side effects of treatment, the inability to predict the natural history of a given cancer, and patient comorbid conditions that may ultimately affect the patient’s likelihood of succumbing to prostate cancer morbidity and mortality. The question of whether screening digital rectal examination and PSA improve mortality and morbidity awaits the results of ongoing clinical trials such as the Prostate, Lung, Colon, and Ovarian (PLCO) trial sponsored by the National Cancer Institute. However, prostate screening appears to have resulted in a substantial stage migration in diagnosed prostate cancers to earlier, potentially curable stages; metastatic prostate cancer at initial diagnosis may become a historical footnote.

Factors that increase the risk for prostate cancer include increasing age, prostate cancer in first degree male relatives, the male hormonal testosterone milieu, race and dietary fat. Some studies associate increased dietary intake of fruits and vegetables with a reduced risk of prostate cancer.

Although it may be increasingly evident that dietary choices play a role in the development of prostate and other cancers, changing patterns of dietary behavior and life-long intervention makes this strategy difficult in practice. Since the 1980’s, chemoprevention, the use of natural or synthetic substances to reduce the risk of developing cancer, has become an important focus of National Cancer Institute-sponsored clinical trials. Since the development of prostate cancer appears to be age-dependent, any intervention that reduces the incidence of clinically significant disease by five, 10 or 15 years would significantly reduce prostate cancer morbidity and mortality. For the chemoprevention of prostate cancer, a number of options have been considered: retinoids, DFMO, inhibitors of cholesterol biosynthesis, alpha-tocopherol, anti-androgens and 5-alpha reductase inhibitors.2 Recognition of the importance of the androgenic milieu on the prostate in the development of prostate cancer resulted in the Prostate Cancer Prevention Trial (PCPT) using finasteride (Proscar). This trial began accrual in October 1993 and ended in May 1997 with enrollment of over 18,000 participants nationwide. The study tests the ability of finasteride, a 5-alpha reductase inhibitor, on reducing prostate gland dihydrotestosterone and, hence, a possible reduction in the incidence of prostate cancer. Final analysis is expected in 2004.

Primary prevention of prostate cancer through dietary supplementation now appears to be a promising strategy to reduce the morbidity and mortality of this disease. Secondary analyses of data from two prospective, randomized cancer prevention trials with selenium and vitamin E suggested these two agents for a second large-scale clinical trial. In a clinical trial conducted by Clark et al., prostate cancer incidence was reduced by two-thirds among men receiving daily selenium supplementation.3 In the Alpha-Tocopherol, Beta-Carotene (ATBC) Cancer Prevention Study carried out in Finland, there was a one-third reduction in prostate cancer incidence and a 40% reduction in prostate cancer mortality in men randomized to receive vitamin E.4 A confirmatory trial, SELECT, the Selenium and Vitamin E Cancer Prevention Trial, with prostate cancer incidence as one of the primary endpoints will substantiate these findings.

The primary objective of SELECT is to assess the effect of selenium and vitamin E, either alone or in combination, on the incidence of prostate cancer diagnosed during routine clinical practice. Secondary objectives include assessing the impact of selenium and vitamin E on the incidence of lung cancer, colon cancer and all other cancers; on cancer-specific survival and overall survival. Quality of life, evaluation of molecular and genetic markers of cancer risk, other biomarkers, and measures of nutrient intake will also be assessed. An ancillary study called PREDAWISE for Prevention of Alzheimer’s Disease by Vitamin E and Selenium Trial, will recruit from the SELECT participant pool, screening for changes in short-term memory or other forms of dementia.

Enrollment to SELECT, a National Cancer Institute-sponsored trial, began in July 2002. More than 32,000 men at over 400 sites in the United States, Puerto Rico, and Canada will be recruited. Enrollment is estimated to take five years, with the entire duration of the trial being 12 years. The University of Hawaii Minority-Based Clinical Oncology Program, administered by the Cancer Research Center of Hawaii, is one of the sites selected to conduct this study.

Eligible males must be age 55 or older (age 50 and older for African-American men), have had a non-suspicious DRE and a total PSA less than or equal to 4.0 ng/ml within 364 days of randomiza-

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Surprisingly, one million new cases of skin cancer are detected every year. One person an hour in the U.S. dies from melanoma, the deadliest form of skin cancer. If you spend a lot of time in the sun, you should protect yourself. One out of five Americans develops skin cancer during their lifetime. Don’t be one of them. Stay out of the midday sun. Cover up. Wear a hat. Seek shade. And use sunscreen. For more information on how to protect yourself from skin cancer, call 1-888-462-DERM or visit www.aad.org.
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intended to provide paraprofessionals working in elder care with background information about aging. The workshop for home health aides, care aides and adult day care assistants on the Big Island includes the following five training modules: the aging process, health and wellness, illness and disability, basic caregiving skills, and death, dying and bereavement.

In 2002, the COA embarked on a strategic planning process to determine how to better serve the Center’s constituents. The primary commitment is to serve the University of Hawaii system, including students, staff, and faculty. As academics, the staff creates and disseminates new knowledge. As a state-supported educational unit, it is responsible to state and local agencies to improve the quality of life for adults and elders, as well as to recognize and help meet the needs of the aging public.

For more information on the Center on Aging, call 956-5001 or visit the web site at www.hawaii.edu/aging.

References
It's A Happy Talent When You Know How To Play.

In the 2002 winter Olympic games at Utah, the United States luge and bobsled teams performed, not merely better than ever, but beyond expectations. Part of the great improvement in results is attributed to the “visual training” directed by Barry Seiler, M.D., a practicing ophthalmologist at the Visual Fitness Institute, at Vernon Hills, Illinois. The devices used include high-tech computer displays and various string and bead tools. Exercises are designed to evaluate and improve visual skills such as peripheral vision, depth perception, contrast sensitivity, speed of focusing, tracking with eye-hand-body coordination and visual acuity. By providing the athletes with a high degree of visual confidence and reaction, correct moves can save hundreds of a second in extremely high speed events. Visual fitness and training seems sure to become a routine part of athletic training for high speed events.

He Has The Body Of A God ------ Buddha.

It is known that one in three Americans is overweight and one in five is obese. Rand Corporation of Santa Monica, California, completed a cost analysis of 10,000 adults ages 18 to 65 in evaluating medical expenditures. While there has been a proliferation of prevention programs in schools and workplaces about tobacco, substance abuse and alcohol consumption, body weight has not been seen as anything to worry about. The study found that obesity is associated with an average increase in medical costs of $325 annually, smoking is linked to an increase of $230, and drinking problems with an increase of $150 beyond the average. (I believe that the last figure is misleading since many auto crashes, home accidents, and domestic violence are actually due to alcohol abuse.) The Rand report was summarized, “We can’t nail down costs exactly, but the very strong effects of obesity are clear.”


Pill pushing is very big business in the United States. Europe, with a greater population than the U.S., spends less for drugs. The European Union has a ban on prescription drug advertising which is believed to help keep health care costs under control. Now, what a surprise, the drug makers want the ban removed, and argue that it unfairly crimps patients’ access to information, and thereby access to drugs. Two thirds of the $6 billion in world wide sales in 2000 was racked up by U.S. contributions to the pharmaceutical industry. The European commission is considering allowing drug makers to market treatments for AIDS, diabetes and respiratory problems. If approved, the measure would allow patients to seek out information on websites, but would not permit other direct ads. Consumer groups argue that relaxing the ban will enable drug companies marketing budgets, push prices up, and do nothing to enhance health care. Amen.

The Judge: A Law Student Who Marks His Own Examination Papers.

The American Tort Reform Association (ATRA) reports that 27 states have no limits on non-economic damages for malpractice complaints. When laws have been passed in the legislatures, personal injury attorneys file suit and fund the cases that have led to limits being struck down. In Oregon, a state court struck down limits established by the legislature, and jury awards of $8 million, $10 million and $17 million resulted shortly thereafter. Nevada has no limits either and insurance premiums have soared. The Los Angeles Times reported that some liability premiums in Las Vegas moved from $37,000 to $250,000. Many doctors are taking the only logical step - they are either quitting or leaving. Already doctor poor, Nevada ranks 47th in number of doctors per unit population. Everyone involved in medical liability knows that the California MICRA statute is the bellwether for controlling expenses, which is why trial lawyers in other states, fight so vigorously whenever it is proposed.


Hawaii’s very own 800 pound gorilla, Hawaii Medical Services Association (HMSA), made the front page of the American Medical News, March 25, 2002. The concern is one of personal privacy for physicians who participate in HMSA’s preferred provider organization (PPO). About 70% of Hawaii doctors are now required to sign a contract to allow HMSA to conduct whatever search deemed appropriate into the doctor’s personal medical records. The American Medical Association has policy opposing any contract to provide care that requires access to a physician’s own medical records. That policy does not discourage HMSA.. Richard Chung, M.D. HMSA credentialing chairman, says that most physicians are granting the authority, but Gerald McKenna, M.D., HMA president, and a handful of Hawaii’s doctors (including your editor) have raised opposition. Do doctors take time to read the contract? Do they understand what the gorilla is ordering? Didn’t Mr. Lincoln sign a proclamation about slavery?

Any Woman Is Happy As Long As She Looks Younger Than Her Daughter.

The world of narcissism remains wide open for creative surgeons. In New York, a cosmetic surgeon is capitalizing on the trend of navel-baring and low-rise jeans by building a better belly button. The youthful navel is vertical, but after weight gain and child-bearing, women often sport a puffy, round, less appealing perspective. By doing a little lipo-suction, a mini-tummy tuck, tightening a few stomach muscles, and giving the skin a vertical stretch, voila! — the teen age belly button returns. Price tag - $8000 to $12,000, cash in advance, please.

Civilization Is The Progress Toward A Society Of Privacy.

Where does the matter of privacy prevail when weighed against suspected drug use? A 16 year old honor student, choir member, musician, and member of the academic team (and later accepted to Dartmouth) was randomly drug tested (her English teacher and academic team leader outside the door, listening). The test was negative. The student was angry and filed a lawsuit alleging invasion of privacy. The school district said the random testing is a response to “a longstanding problem of drug use” in the community. In all, 484 tests were conducted on students involved in extra-curricular activities over a two year period, and three were positive. Tecumseh, Oklahoma, is not a high drug use community. The U.S. district court supported the school’s program, but was reversed by the U.S. appeals court, saying drug use among students subject to the testing policy was negligible. The case has percolated up to the Supreme Court of the United States.

It Is Not A Fragrant World.

And on more “reefer madness” in Ottawa, Canada, a school board suspended a 15 year old boy because a drug-sniffing dog barked at his jacket. No drugs were found, and the student claimed to have nothing to do with marijuana or any other drugs. The jacket could have hung next to a drug-contaminated coat in a closet, made contact on a bus, or even brushed against one in the street, or perhaps the dog was wrong. So, whom do you believe, the dog? The boy? A police spokesman who handles drug-searching dogs, said much more than a bark from a drug-sniffing dog is required for evidence, but the “zero tolerance” school board at the Catholic high school has refused to back off. Book ‘em, Danno!

Ah, The Power Of The Electorate.

Wishing to allow service people to have a vote by the Internet in the last national election, the Pentagon established a project for soldiers to cast their ballots using computer science. Cost of the project was $6.2 million, and the number of votes cast -- eight-four (84). The cost per vote was $74,000! Your tax dollars at work.

ADDENDA
• Eyelashes recycle in 90 days.
• Each day, Americans eat 18 acres of pizza.
• Doctors claim cheerful people resist disease better than grumpy ones. The surly bird catches the germ.
• What do you get when you date a clown? Carnival knowledge. Aloha and keep the faith —rtst

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